FINAL COURT-ORDERED PLAN

TRANSITIONAL RECEIVER

DENNIS R. JONES

DIXON, ET AL. v. WILLIAMS

C.A. No. 74-285

March 28, 2001

TABLE OF CONTENTS

I. BACKGROUND AND OBSERVATIONS

A. History of the Dixon Lawsuit

In February 1974, a class of individuals civilly committed to St. Elizabeths Hospital, including lead plaintiff William Dixon, filed suit against the Federal government (which operated St. Elizabeths) and the District of Columbia (which was responsible for community mental health centers in the District). The plaintiff class, which ultimately included individuals at future risk of hospitalization due to the lack of community services, sought community-based mental health treatment for class members whose mental illnesses were not deemed by their treating professionals to be sufficiently severe to require hospitalization.

In December 1975, the District Court ruled that individuals subject to the Ervin Act have a statutory right to treatment in the least restrictive setting, including placement in alternative community facilities when treating professionals have determined such treatment is appropriate. In 1980, following two years of negotiations, the Federal and District defendants and counsel for the plaintiff class, agreed to the entry of a consent order and an implementation plan. The order established the Dixon Implementation Monitoring Committee as a mechanism for overseeing the execution of the Plan, including tracking the availability of necessary resources, advising the Court on systemic obstacles to reform, and reporting the concerns raised by the class members.

The Federal government transferred St. Elizabeths Hospital to the District of Columbia in 1987. This reorganization brought all of the District's mental health service components together under a single administration — the newly created Commission on Mental Health Services ("CMHS"). A new consent order and a 5-year Services Development Plan ("SDP") were approved by the Federal Court in 1992. When the District failed to meet its obligations thereunder, a Special Master was appointed in May 1993 to oversee the implementation of the SDP, the 1992 consent order, and prior Court orders.

In May 1995, as a result of a motion by plaintiffs to expand the powers of the Special Master into those of a Receiver, a new consent order was entered by the Court. The order provided for a $12 million increase in the community adult mental health services budget and for the engagement of outside consultants to review the management of CMHS and the Mobile Community Outreach Treatment Team ("MCOTT"). While these "Phase I" conditions were achieved, the "Phase II" recommendations — which called for the implementation of a management audit, the establishment of two MCOTTs, and the development of a Homeless Services Plan, among other things — were not successfully implemented.

In December 1996, based on the District's repeated non-compliance with the Dixon decrees, the plaintiffs again moved for the establishment of a Court-ordered Receivership. The Federal Court heard the motion in April 1997, and granted it in June 1997. The Court's order bestowed upon the Receiver broad powers over personnel, contracting, facilities and the budget. The overriding charge included the mandate for development of an integrated and comprehensive community-based system of care.

The first Receiver was appointed in October 1997. In October 1999, the Court heard a request from the plaintiffs for an independent audit of CMHS activities under the Receiver. The parties and the Receiver subsequently agreed to an audit of CMHS budgeting, procurement and patient account management, and to a stakeholder committee process to assess progress on issues of concern. Continued frustration with the pace and direction of progress ultimately led to the resignation of the first Receiver in March 2000.

Following negotiations among the parties, the Court issued a consent order establishing a Transitional Receivership starting April 1, 2000. The order stated that day-to-day operations of the mental health system would be returned to the District by January 1, 2001, at the earliest, or April 1, 2001, at the latest. The Transitional Receiver was charged with developing — in consultation with the parties — an integrated, comprehensive and cost-effective community-based plan for the provision of mental health care in the District (the "Plan"). This is that Plan.

Beginning with the assumption of day-to-day operations by the District, a probationary period not to exceed six months is to be used to determine whether the District has the capacity to implement, and is implementing, the Plan. The Transitional Receiver is to monitor the District's performance for the Court during this period. If the Transitional Receiver certifies that the District has the capacity to implement and is implementing the Plan, the Transitional Receivership will be terminated.

B. Observations on the Current State of the System

The central question that pervades the last 25 years of legal and organizational activity in the District mental health community is: What have we learned in that time that might be instructive in our planning for the future? Each person and organization involved in the long and frustrating process brings to this query a unique perspective forged from hard-fought, hard-earned experience. Because I am an outsider, however, I think I bring to the mix a different perspective, and perhaps one less affected by the trials and tribulations others have experienced in getting to this point. A few of my observations follow:

1. The Need for Direction

Although a plan for the future direction and development of the public mental health system in the District was drafted and approved in connection with the transition of St. Elizabeths to the District's control, neither it nor other plans developed over the years were ever fully implemented. This has often left many well-intended actors in the system moving in different directions and at different speeds. We must put in place a comprehensive Plan that will provide clear direction for the system.

2. The Need to Establish a Separate "Authority" Responsibility

Historically, CMHS has both served as a provider of services and tried to oversee a fragmented, very dependent and largely underdeveloped system of care. The lack of any meaningful separation of these very diverse and inconsistent roles has led to endless confusion and often animosity within the system.

Even more problematic is the fact that when an organization, such as CMHS, attempts to function as both an authority and a provider, overall capacity questions are raised relating to the entity's ability to fulfill both roles. As a result, the critical (and non-delegable) "authority" tasks of creating and sustaining clear goals and values for the system tend not to receive the necessary attention. This historical barrier to CMHS success has been made essentially insurmountable by a confusing web of existing statutory requirements and limitations, as well as the lack of a legislative mandate requiring CMHS to promulgate and implement a set of system-wide goals and values.

We must establish a mental health agency with a meaningful separation between its authority and provider functions, and the unambiguous responsibility and authority, and the necessary resources, to promulgate and sustain clear goals and values for the system.

3. The Need to Redefine the Provider Role

Confusion and incapacity issues such as those faced by CMHS have led most governmental jurisdictions across the country to get entirely out of the business of directly providing outpatient/rehabilitation services. While it is not unusual for state governments to continue to operate public inpatient "safety net" facilities to supplement private inpatient capacity, it is now highly unusual for the governmental entity to be a major provider of community services. We must develop a publicly funded system with the incentives and capability for utilizing both public and private mental health services in the most appropriate and effective manner possible.

4. The Need for Clear and Sustained Leadership

For CMHS, a multiplicity of players and power bases across the executive, legislative and judicial arms of District government has led to a great deal of stalemating, inertia and stop-start activities. Symptomatic of this dynamic has been the continual change in leadership. The ability to attract and support high-quality, stable leadership must be viewed as a priority for the future.

5. The Need for the System to Embrace Change

The fact that the Federal Court has been involved with the District's mental health system for more than twenty-five years makes it clear that judicial intervention alone cannot bring about systems change. Fundamental and lasting systems change must come from within; it cannot be forced from the outside. We must create a mental health system that nurtures an environment that meets the needs and inspires the confidence of the stakeholder community.

6. The Need for Infrastructure

In order to provide comprehensive and functional mental health services to District residents, the mental health system must be supported by underlying systems for policy development, budgeting, purchasing, and information storage and retrieval. The historic ineffectiveness of such basic infrastructure systems throughout the District creates unique challenges for any policy initiative. It is easy to agree, for example, that a new financing mechanism for community services is long overdue. However, creating the necessary infrastructure to help make this happen is a daunting task. This Plan must put in place the resources necessary to create the infrastructure needed to operate an effective and responsive mental health system.

7. The Need for Productive Collaboration

The effectiveness and efficiency of the District's mental health system are dependent on the active support of other key City agencies. Other District agencies and the populations they serve are likewise dependent on coordination and cooperation with a well-functioning public mental health system. Without such collaboration, problems are typically addressed only in part, and creative opportunities to devise comprehensive solutions to "big picture" issues are lost. It is increasingly apparent that strong City leadership is necessary to create needed cross-agency collaboration. We must put in place a Plan that empowers the mental health system to play a leadership role in such collaboration.

8. The Need to Nurture Optimism

The amazing thing is not that the current system has bred numerous pockets of anger and frustration. The surprise is the number of people who continue to hope, and to find ways to make hope real — in spite of the system's shortcomings. The blueprint for the future must build on the system's strengths, and the undaunted commitment and devotion of many key people must be acknowledged and utilized.

II. APPROACH TO DEVELOPMENT OF THE PLAN

A. Purpose of the Plan

The purpose of this Plan is to provide an overall policy framework for meeting the Dixon mandate to develop and implement an effective and integrated community-based system of mental health care for consumers in the District of Columbia. It is crafted to achieve a delicate balance. The Plan must be sufficiently descriptive so as to provide strong guiding principles and a clear framework for the current and future direction of the District's mental health services. At the same time, it must retain the capacity to be dynamic as the new system unfolds and evolves.

For example, it is neither possible nor desirable to set out highly specific service targets, as these will change and be adjusted over time. The Plan attempts to create the greatest degree of "tightness" at the broadest level — e.g., clear statements of mission, values, goals, key functions and principles to drive the system — and to provide succinct descriptions of the role(s), governance structure and financing of the District's public mental health authority into the future.

It is imperative that the new mental health system has the capacity to measure itself in key performance areas. The ongoing measurement of system performance from both organizational and services perspectives is critical to ongoing improvement in systems performance. Achievement of this objective requires agreement on the most critical areas to be measured, baseline measures in those areas, and an ongoing understanding that these areas will be measured over time.

The Plan, then, fulfills its purpose in three distinct ways:

- by articulating systems direction, philosophy, key functions and structure;
- by describing how the system's major roles and governance will take shape; and
- by ensuring that the system has the ongoing, built-in capacity to measure itself in key areas and to translate these findings into continual improvement.

B. Process for Plan Development

Information, impressions and advice concerning Plan development have been gathered in a variety of ways and from many sources. The Receiver's Advisory Council has regularly discussed the development of the Plan, raising and proposing Plan components, responses, and implementation activities. Various forums held with interested parties have provided opportunities for discussion and feedback. In addition, individual structured interviews have been conducted with key informants, including executive, legislative and judicial branch officials.

This process has been conducted to create an environment that promotes healthy and organized interaction, discussion and debate. The substance of the Plan is, of course, a matter uniquely reserved to the parties and ultimately the Court. The probability of achieving a successful transition to the new system of care will be vastly improved, however, because the Plan has been discussed and, hopefully, will be embraced by the wider governmental and mental health community.

III. KEY ELEMENTS OF THE NEW MENTAL HEALTH SYSTEM

A. Mission: Dynamic Systems of Care Built on Consumer Needs

The overall mission of the new District of Columbia mental health system is to develop, support, and monitor an effective and integrated community-based system of services for persons with identifiable mental health needs. To accomplish this mission, the system must be restructured to perform the different and more diverse functions necessary to significantly increase the total number of persons served.

As with any such system, the priority in service response and system design should be on those individuals with more severe forms of mental or emotional illness. This includes those who fall within the federally-accepted definitions of severely and persistently mentally ill adults or severely emotionally disturbed children and youth. Individuals with the highest degree of symptomatology and at greatest risk of pain and suffering have a higher probability of becoming a burden on their families, suffering academic failure, being incarcerated, abusing alcohol and other drugs, etc. Left untreated, these individuals disproportionately consume resources of numerous public systems, such as schools, child welfare agencies and law enforcement programs.

Contemporary mental health systems — when truly consumer driven — offer greater potential for serving individuals, including persons with severe illnesses, than ever before. In such systems, newer medications combine with a community system flexible enough to meet individual needs to provide consumers with a new sense of dignity and hope, as well as demonstrated participation and success in the larger community. Such a system will be "recovery based."

Such ends can only be achieved in a mental health system that is integrated, community-based, and provided primarily in the consumers' natural environments (e.g., schools, homes, neighborhood health clinics). These characteristics permit greater partnering with other helping professions, earlier identification of mental health issues, and reduced stigmatization. Further, the most significant strides can be made when progressively greater resources are targeted toward prevention and early intervention efforts focused on younger people and located in community settings.

At the heart of the new mission for the District's public mental health system is the need to create dynamic systems of care built on consumer needs. Meeting this obligation requires demonstrated commitment to a system-wide services philosophy that is:

- Person-centered: For children and youth, this means child-centered and family-focused. For both adults and children and youth, it means that the system must fundamentally align itself so as to respond to the unique types and mix of services each person (and family) requires.

- Community-based: The locus of services as well as accountability and defined decision-making responsibility should be at the community level.

- Culturally competent: Agencies and individual staff should be responsive to the unique cultural, racial and ethnic differences of all who are served.

B. Internalization of Consumer-Driven Core Values

In the reformed mental health system, all efforts, resources and behaviors must reflect the view that "the consumer is in charge." Core values must be defined, adopted, and translated into concrete behaviors and practices at each level of the organization. A consumer-driven process facilitated by the Transitional Receiver has identified the system's core values as respect, accountability, recovery-based, quality, education and caring. These values have been adopted, and are described more fully, in the Receiver's FY 2001 Strategic Plan.

Monitoring conformance with these values through standards and contracts is one powerful way to ensure that the system is consumer-driven. Broad and consistent commitment to these values should also underlie and thereby help stabilize relationships between the mental health system and external constituencies, such as courts and other agencies, and internal stakeholders, such as system employees. CMHS has already begun to successfully implement consumer-driven values with the CarePoint Project. This kind of effort must be continued and expanded.

C. Mandated Separate and Independent Authority Role

The new District mental health agency, hereinafter the "Department of Mental Health" (the "Department" or "DMH"), will be created as a cabinet-level agency, with its Director reporting directly to the Mayor's Office. The key task of the new Department must be to provide the governmental leadership and oversight functions necessary to manage a complex and pluralistic community mental health system. The new Department's structure and authority must give it a clear mandate to play this key role actively and aggressively. This authority must be separate and distinct within DMH's structure, with clear demarcation between the authority role and any role DMH plays as a provider. This is important not only because the work of an authority and a provider are vastly different, but also because the "authority side" of the Department will have certification and licensure responsibility for all mental health services and programs — including any that the Department may deliver directly.

1. DMH's Powers and Duties

Legislation establishing the new Department must grant DMH the powers and duties necessary to carry out its "authority" responsibilities. Key authority functions include those discussed below.

a) Quality Improvement and Provider Oversight

In order to carry out the new comprehensive regulation and licensing mandate described below, DMH will hire adequate numbers of trained staff to certify and/or license and monitor all non-hospital mental health facilities and programs for which licensure is required under District law, including specifically Community Residence Facilities, Medicaid Day Treatment Programs, Free-Standing Mental Health Clinics, Residential Treatment Centers for Children and Youth, and Mobile Community Outreach Treatment Team Services. It should be noted that individual professionals will continue to be licensed according to current practice, and therefore will not be licensed by DMH. The Department will also develop standards for certification of Core Service Agencies (described in detail below) and specialty service agencies. Through its quality improvement and provider oversight function, the Department will implement means to stimulate, oversee and reinforce the values of a consumer-driven model.

b) **Planning and Policy Development**

DMH will be responsible for mental health planning and policymaking. It will develop the District's mental health plan and take a leadership role in ensuring that the planning and policies of other District agencies are consistent with the District's mental health plan. DMH will also promulgate policies and rules to govern the mental health system. DMH will develop and adopt an annual strategic plan which will be used to measure system performance throughout the year.

The annual strategic plan will build upon the Receiver's Plan and will incorporate specific tasks and timelines, and provide for clear management accountability for their accomplishment. The Department will involve consumers, community stakeholders, providers and staff in its planning processes.

c) Medicaid Responsibilities

The Department will utilize Medicaid as a major funding source for community-based services and will seek to maximize Medicaid reimbursement at both the services and administrative levels. DMH will administer — via written agreement with the Medical Assistance Administration ("MAA") — those portions of the state Medicaid program relating to mental health. DMH must therefore have the delegated authority to fulfill all of the responsibilities of a health plan, in active collaboration with the MAA.

The Department will implement the Medicaid Rehabilitation Option ("MRO") to support an array of community services for Medicaid eligible individuals. Over the past fifteen years, more than 40 states have used the MRO model. It is now the single most significant method of federal reimbursement of community mental health services, particularly for adults with long term disabilities and children and youth with significant emotional problems.

The Department must have the ability to develop specific MRO services, fee for service rates, eligibility criteria, information systems, payment mechanisms, etc. While substantial progress has been made during the development of this Plan, full implementation of the MRO will take a minimum of 18 to 24 months, and will require a continuing commitment of resources. A specific MRO plan with key tasks and timelines will be shared with providers and advocates.

d) **Systems of Care Management**

DMH will play the key leadership role in the design and development of an overall "systems of care" model. These systems of care will address the challenges faced by adults, children and youth with more severe forms of mental illness and/or emotional problems, who often must deal with multiple and often unconnected service systems. Implementing this model will require DMH to take the lead in developing alternative approaches to the planning, funding and delivery of services. These approaches stress strong cross-agency partnerships, a shared responsibility for ultimate outcomes, mobile/onsite responses by mental health professionals, a shared philosophy of consumer-driven services and family-driven supports, and the mixing and matching of funding streams to support an overall services plan.

In developing systems of care, the Department must exhibit leadership in serving the special populations and services for which it will be responsible, including children and youth and adults, with particular attention to individuals who are homeless, have a forensic status, or need housing and other special supports. Leaders responsible for each of these special service areas must develop a clear vision, create cross-agency partnerships, and involve consumers and family members as full participants in service planning and evaluation. Under the systems of care model, DMH should also develop utilization management strategies to assure that consumers receive the right services, in the right amount, at the right time.

e) **Child, Youth and Family Services**

Effective services for children, youth and their family must be developed and organized by the new Department. DMH must establish, through an interagency workgroup, a cross-systems approach to funding, policymaking and establishment of a single system of care for children and youth with mental health needs. New MRO services, especially community based intervention, must provide alternatives to out-of-District placement of children and youth. Care management strategies, including streamlined, integrated service planning that meet the needs of children and youths and their families in a variety of settings, must be implemented across all systems of care. Service strategies including school based service strategies, must also be put in place. Strategies aimed at supporting and treating children who are the responsibility of the Children and Family Services Agency ("CFSA"), or the Youth Services Administration ("YSA"), or who are homeless or separated from their families, must be a priority. All services must be consumer and family based, with families playing an integral part in service planning and decision-making.

f) Consumer and Family Affairs

Departmental planning and evaluation must involve consumers and family members at all stages to instill across the agency a deeply-held belief that the people best equipped to evaluate priorities and practices are consumers themselves. Like most state departments of mental health, CMHS has created a separate Office of Consumer and Family Affairs ("OCFA"). While this is an important first step, it does not — in and of itself — accomplish the end goal of creating a consumer-driven system of care. To do this, leaders and managers at all levels must embrace consumer involvement in the design, implementation and evaluation of services. For example, this Office could direct the monitoring and measurement of the system's conformance to the consumer driven core values. The new OCFA will have its own discrete budget, and will continue to be a full partner in the team that leads the Department's delivery systems efforts.

g) Organizational Development and Training

As services are reformed, the size and responsibilities of the Department's workforce are likely to change, and the need for training and staff development will intensify. All staff providing services will be required to demonstrate knowledge and performance competencies in a range of areas, including the recovery model and cultural competence. The Department will establish a Training Institute, develop strong working relationships with local universities and other professional resources, and provide a continuous learning environment for consumers, community stakeholders, staff and providers. It is also critical that the Department work with organized labor to find effective ways to manage the ongoing retraining and redeployment of staff throughout this dynamic period of change.

h) Enforcement of Consumer Rights

Consumers and their advocates need effective administrative mechanisms to enforce statutory protections for consumers of public mental health care. The Department must, through the thoughtful and innovative involvement of neutral third parties, develop and implement non-judicial processes to protect consumers and address their grievances. Fundamental fairness, such as the meaningful opportunity to be heard, whether individually or through one's representatives, and real enforcement consequences, must be hallmarks of such a system, and must be proposed by the Department in rules adopted with the support of community stakeholders. Fortunately, there are many successful models that can be explored. Implementing the fair hearing processes required under federal Medicaid law will be a good beginning, but the Department must extend these kinds of protections to all consumers of public mental health care. It is important that the development and initial implementation of a consumer protection process and full and fair grievance procedures be accomplished before the end of the Receivership.

2. DMH Leadership Roles

Many DMH leadership positions will report directly to the Director of the Department, have responsibilities that cut across agency lines, and exercise authority that traditionally has been held by other District officials (such as full procurement and personnel authority). In exercising such authority, the Department's leadership will follow the substantive laws and policies of the District and work collaboratively with District leaders to ensure cross-agency teamwork and participation. If existing laws and regulations impede implementation of the Plan, the Director will consult with the Mayor to develop an appropriate resolution. This cooperation will balance the legitimate and important District-wide control function with DMH's mental health system responsibilities and strong consumer service and support philosophy.

a) Chief Financial Officer

The financing and delivery of health care is a complex endeavor. The Department's Chief Financial Officer ("CFO"), will be appointed by the District's CFO in collaboration with the Director. The CFO will directly report to, be ultimately responsible to, and be under the supervisory direction of the District's CFO, through the Director. The CFO will be responsible for working as part of the DMH leadership team to develop fiscal strategies consistent with the overall direction for the system and in compliance with applicable District and Medicaid laws and policies. The CFO will advocate for and advance the policy objectives of the Director, to the extent consistent with his or her ultimate responsibility to and supervisory control by the District's CFO. The CFO must put into place sound budgeting systems, establish and maintain clear accountability for management responsibility, produce financial and performance reports on a timely basis, develop financial policies that ensure adequate internal controls, monitor the fiscal development and performance of both DMH and private providers, and develop and implement the billing systems that will be necessary to support MRO and other contracts.

b) Chief Information Officer

The new Chief Information Officer ("CIO") must establish the information systems policies and technology to support an increasingly community- and third party provider- based mental health system. The CIO must work in partnership with internal and external provider entities in offering information systems training, support and consultation. These responsibilities will require capital investment in both hardware and software. The CIO will actively coordinate with the Office of the Chief Technology Officer ("OCTO") in establishing needed information systems' plans and policies.

c) **Governmental Relations**

The Department will maintain an active Governmental Relations function that will work collaboratively with the District's Office of Intergovernmental Relations to influence, monitor, and educate key governmental players as part of an overall governmental relations strategy. As the Department's authority role develops, a proactive legislative agenda must be developed. Department leadership will work with mental health advocates, the Mayor's office, other agencies, City Council members, and at times with congressional offices. As federal and local legislation is passed, the Office of Governmental Relations will educate DMH leadership, staff, and advocates concerning new requirements and/or opportunities (e.g., new funding opportunities).

d) **Public Relations**

The Department will maintain an active public relations function with responsibility for media relations, communications within the system and among Department-run programs, and the development of effective public education efforts. As community services increase, DMH will have both the opportunity and the need to help neighborhoods, churches, schools and the general public better understand the nature of mental and emotional illness. This ongoing effort should be planned with input from consumers and advocates, as well as communications professionals. The Department's public relations function will operate in collaboration with the Mayor's Communication Office.

e) **General Counsel**

The Department must establish an Office of General Counsel to serve as the principal legal advisor to DMH with respect to its authority functions. The Office of the General Counsel will be organizationally separate from the Office of Corporation Counsel currently located at St. Elizabeths Hospital, which will continue to represent the provider side of the Department and serve as outside legal counsel for the Department on litigation matters. The General Counsel will have an attorney-client relationship with the Director and will be included as a senior executive in policy deliberations concerning the Department. The General Counsel will be appointed by the DMH Director with the approval of the Corporation Counsel. The General Counsel will advocate vigorously for the Director's position on legal issues, and if such advocacy poses a conflict with a legal position of the Corporation Counsel, will seek exemption from the Corporation Counsel's supervision as to that position in accordance with section 855(b) of the D.C. Government Comprehensive Merit Personnel Act.

f) **Compliance Officer**

Contemporary health care organizations put in place mechanisms to assure compliance in a complex, highly-regulated environment. The Department will employ and designate a Chief Compliance Officer, who will develop and implement a corporate compliance plan that includes the nationally accepted elements of a health care compliance plan. The plan will include the requisite training of staff to ensure compliance with HCFA rules. In addition, the Compliance Office will develop the capacity to conduct auditing of both Department-run and contracted-for agency programs, in order to investigate potential contract, billing or management non-compliance and recommend appropriate remedies for correction.

g) **Clinical Officer**

The Department will employ a Chief Clinical Officer, who will be a Board-certified psychiatrist, to function as the clinical leader for the authority side of DMH. Among other duties, the Chief Clinical Officer will have responsibility for setting hospital admissions criteria for patients receiving publicly funded mental health care and for setting up systems to monitor the care of persons committed to the Department by the courts.

D. <u>Core Service Agencies</u>

A key objective of this Plan is the reliable and effective provision of mental health and related services to adults, children and youth, and their families, no matter how complex their needs, with maximum consideration given to consumer and family choice in treatment. A key to achieving this goal is organizing the system in a manner that assures that each consumer has his/her own "clinical home": an entity responsible for and accountable to that consumer for the full array of their service and support needs on a continuous basis, regardless of the consumer's legal, clinical or physical status. At the consumer level, this entity is responsible for assuring that mental health services are maximally integrated with other service systems with which the consumer interacts. Thus, the clinical home will assure access, promote continuity, prevent unnecessary institutional reliance, and avoid cost shifting; DMH is likewise responsible for these outcomes at the system-wide level.

This provider "home" will be referred to as a Core Service Agency (CSA). Each CSA will be charged with carrying out treatment planning responsibilities for any person served by that CSA in the mental health system. A CSA must provide directly four key services for both adults and children and youth: diagnosis/assessment, community support services, medication and somatic treatment, and outpatient counseling/psychotherapy. The CSA may arrange to have some services delivered by other providers under sub-contract with the CSA, pursuant to very specific requirements.

CSAs must offer access to rehabilitation, assertive community treatment, community based intervention, and partial hospitalization and crisis emergency services, either independently or through formal, uniform agreements with qualified specialty service providers. CSAs shall also offer directly, or arrange for, if needed and clinically appropriate, other services, including residential services, housing, psycho-educational services, day programs and peer and family supports. CSAs must accept clinical, financial, and legal responsibility for services they provide directly and through their sub-contractors.

The Transitional Receiver's Office has developed Medicaid certification standards for CSAs. MAA intends to adopt rules implementing these standards for Medicaid services, and they will become the Department's standards for all community-based services. Central to these standards and their implementation are the following requirements:

- CSAs must assure that consumers and families are provided timely and accurate information, that consumer communication needs are addressed, that staff are fully oriented to the service delivery system and to a wide range of consumer needs, that services are made available in accordance with standards for emergent, urgent and routine need, and that consumers' rights relating to access to services, treatment planning and service delivery are fully explained and protected.

- CSAs must assure that clinical operations, documentation and treatment planning process are streamlined, consumer- and family-centered, culturally competent, and meet a high level of professional standards in providing care.

- CSAs must assure that consumers and their families have freedom of choice and the ability to access needed services and that services are effectively monitored to assure quality and continuity of care.

- CSAs and DMH must assure that children and youth and their families are afforded child/youth and family specific services with the same level of attention as services provided for adults.

Working with each consumer and his or her family or representatives, as appropriate, each CSA will authorize treatment by developing Individual Plans for Care ("IPC") for all children and youth, and Individual Recovery Plans ("IRP") for all adults receiving services. IPCs and IRPs will state as objectives the specific consumer or family strengths to be built upon, skills to be developed, and identify needed services and resources to be changed, modified or secured to achieve each goal. IPC requirements will be based on evidence-supported and family-centered service approaches, and IRP requirements and prototypes will draw from the recovery approach to treatment planning and service delivery.

Each CSA will assure meaningful involvement of adults, children and youth and their families in their own treatment planning and choice of services throughout their course of treatment. For adults, family involvement will occur only with the consumer's own expressed consent. CSAs will be required to measure respect, consumer satisfaction and dissatisfaction, and meet access and cultural competency standards as part of the DMH certification requirements.

The CarePoint Project has begun to demonstrate the value and effectiveness of focusing responsibility and performance incentives for individualized services and supports within a single community-based entity. This model must be adapted to take full advantage of the MRO funding and approach. The involvement of consumers in both staff and advisory roles is an additional facet of the CarePoint model that should be examined and replicated.

E. Improving Crisis Response and Access to the System

Providing timely, effective and holistic assistance to persons experiencing psychiatric crisis or emergency is critical to such persons, their families and significant others, and to the safety and health of the citizens of the District. Crisis response is a primary function of a public mental health system, which must be able to intervene in a wide range of crisis and emergency situations with services which identify and quickly address underlying problems or conditions — such as a developmental disorder, a history of abuse, trauma, or a medical or legal problem — and return the person to routine functioning as quickly as possible.

CMHS has begun constructing the pieces of a crisis emergency system, which will be planned and coordinated with the District's existing emergency response systems, including the Metropolitan Police Department and Emergency Medical Services. The Comprehensive Psychiatric Emergency Program ("CPEP") and Children's Intake Division ("CID") were developed in response to the need for a comprehensive crisis system. Compared to other communities of comparable size, however, the current system is seriously lacking in capacity to serve people experiencing a range of crisis needs. These shortcomings are particularly acute with respect to crisis stabilization and quick, on-site, mobile response. The current system also severely under-serves children and youth, lacks capacity to provide services to children and youth served by other child-serving systems, and is extremely costly relative to the total number of persons served.

Access to the new mental health system, which often occurs initially in response to a crisis, must be highly flexible and well-organized. As has been discussed above, MRO will provide consumers with access to a wider array of

services and programs than has been possible in the past. But MRO also requires improved coordination, particularly at the front door to the system, to enable consumers to take advantage of this broader access and assure them a choice of provider.

1. The "Hub" Approach

This Plan calls for the construction of a stronger and better-integrated Access Crisis Response System based on a "Hub" concept at the center, with a range of crisis service options available to meet consumers' varying crisis needs. Under this model, DMH will directly operate core functions of the "Hub". It will also ensure the availability of a more flexible array of other services through very specific third party contract agreements or through direct provision of such services if necessary. The Department will concentrate on activities that enhance access to the system for all consumers, their families, other health care and safety personnel and providers.

A key element of the Hub model is a 24-hour, 7-day-a-week telephone hotline, information and referral, dispatch and triage center, operated by DMH. This center will be located at a central single site. Specifically, it will:

- provide initial telephonic professional assessment, crisis intervention and triage for persons presenting for service;
- dispatch crisis mobile teams as appropriate after initial and immediate assessment;
- coordinate access and link persons to out-of-home crisis stabilization services;
- provide crisis back-up telephone, triage and dispatch support to site-based psychiatric crisis-emergency and crisis stabilization providers, as well as other health and safety systems (e.g., police, CFSA, YSA, etc.);
- be a connector for consumers and providers to services;
- facilitate communication for the entire system of Department-contracted providers to assure continuity of care and information for persons entering the system through this crisis portal;
- provide information on resources available through DMH and private mental health and other health and human services providers, and other information regarding benefits, legal requirements, eligibility, etc., as requested by callers; and
- provide a trained volunteer-based telephone line for persons needing such contact, and for telephone wellness checks.

2. Crisis Response Services

In addition to Hub services, the Access Crisis Response system will include mobile crisis teams, site-based psychiatric emergency services and crisis stabilization services.

Separate Mobile Crisis Teams will be available 24 hours a day, 7 days a week for children and youth, and for adults. All teams will be trained to provide back-up coverage for persons of all ages to assure adequate coverage in the event that demand exceeds available resources. Need and availability of resources should be addressed by the Department at the end of the first year of operation, because demand for this service may be low until the teams gain experience and their existence and value become recognized by health and safety personnel and consumers themselves. Hub dispatchers will prioritize and coordinate teams to maximize this limited resource.

Apart from the Hub, Site-Based Psychiatric Emergency Services must be available 24 hours a day, 365 days a year. Providers (e.g., hospital emergency departments) interested in and capable of providing face-to-face assessment, evaluation and crisis interventions may be authorized by the Department, pursuant to contract, to conduct involuntary commitment evaluations. Sites must be set up and organized to facilitate access and use by health and safety personnel. Adults and children and youth must have separate waiting and treatment areas. Providers must have available a range of on-site interventions, including medication, observation, psychiatric evaluation, crisis counseling and seclusion and restraint. Emergency sites must be staffed to ensure that triage occurs within 15 minutes and that consumers are seen by a qualified clinician within one hour of arrival. Service providers must have agreements with medical facilities or have personnel available to treat medical emergencies within time frames dictated by Medicaid requirements.

Crisis Stabilization services may be provided in the home or outside of the home. The extent to which crisis stabilization services of any sort can be made available, and the type of such services provided, however, will depend largely on the availability of qualified providers and of Medicaid and/or other funding. MRO can help support increased *in-home services* capacity, described as "Community Based Intervention" for children and youth or as a "Community Support Program" service for adults. Interventions are developed with the consumer, and as appropriate, their family. Each individual's crisis stabilization plan may include behavior management, medication monitoring, safety checks, overnight support, crisis counseling and/or interaction modeling if the adult or child consumer is living with his/her family. *Out-of-home crisis stabilization* is provided in respite locations or emergency therapeutic care programs for children and youth and in bridge housing or crisis residences for adults.

3. Ongoing Analysis of Crisis Service Provision

Like all elements of the new mental health system, the Department's crisis response system must be dynamic. DMH will continue to analyze and adjust crisis intervention services as need, efficiency, effectiveness and funding require.

The system described above will likely require funding in excess of that presently available for crisis emergency services in the CMHS budget. The Department will need to devote the entire existing emergency services budget to these services, add additional funds as new revenues become available, and redirect funds saved in other parts of the system. At a minimum, the Hub, the basic Mobile Crisis team configuration, and at least one psychiatric emergency service, must be funded. Crisis stabilization services and additional Mobile Crisis Teams should be added as funds are identified from other parts of the CMHS budget.

In the near term, the Department will continue CMHS's practice of providing crisis services directly. At the same time, however, DMH will assess the feasibility, cost, and efficacy of seeking certain crisis services from private providers. This will be done in a Request For Information process, the results of which should guide future steps. Whether the crisis services are provided directly and solely by the Department (an unlikely scenario), or progressively through contract with private providers (a more successful approach in most jurisdictions), the crisis system must perform in ways that meet established standards and community expectations for responsiveness and performance.

F. Funding Strategies

A long-standing problem of the District's mental health system has been the lack of a clear and sound management approach for maximizing services funding, providing incentives to community providers (including CMHS's direct services), and efficiently and effectively using local appropriated funds.

Persons may not be discriminated against based on their eligibility or non-eligibility for Medicaid, Medicare, or private insurance coverage in assessing or meeting service needs. Rather, the provision of services shall be based upon an individual clinical assessment of the client's needs, consistent with the Department's promulgated rules for priority populations.

1. Maximizing Funding Availability

Federal reimbursement (particularly through MRO) must be maximized for community-based services. Not only will the Federal government pay 70% of the cost of such services, but utilizing MRO creates incentives for providers to deliver services consistent with this Plan and the requirements of the Dixon decree. These incentives will also lead to improved productivity.

MRO-funded services will include diagnosis and assessment, medication and somatic treatment, counseling and psychotherapy, community support, community-based intervention, partial hospitalization, crisis/emergency services, assertive community treatment and rehabilitation. These services will be available to both adults and children and youth. Any willing provider who meets Department certification standards may provide these services. To ensure conformity of service delivery regardless of funding source, the same standards, definitions and requirements will apply to services funded through local funds (including Department funds), as well as to services funded by Medicaid.

The availability and scope of services for individuals who are not Medicaid eligible or of services not reimbursable by Medicaid will by necessity be subject to local funding constraints. However, it is the clear policy intent of this Plan to have clinical and service needs drive the systems response, as opposed to Medicaid eligibility or non-eligibility. Criteria are being established for services not covered by Medicaid and for the amount and type of services available to consumers who are not Medicaid-eligible. It will be important for the Department to utilize Medicaid whenever possible to ensure that local funds can be maximized for non-eligible consumers and non-reimbursable services. The amount of funds needed for the 30% MRO local matching funds, and the impact of that obligation on the overall mental health budget, must be monitored on a continuous basis.

The Transitional Receiver has already entered into a Memorandum of Agreement with MAA to guide the development and utilization of MRO. A State Medicaid Plan amendment has been filed by the MAA to gain Health Care Financing Administration ("HCFA") approval for a start date of April 1, 2001. In addition, the Department's enabling legislation will replace the existing Certificate of Need ("CON") process for mental health services with an alternative planning, review, and approval process for all community-based mental health services and programs, which will be licensed or certified by the Department.

These and other new funding strategies will require the Department and providers to develop new administrative competencies. Previously, the mechanisms used to deliver, document and bill services were tied to the system used at St. Elizabeths, because most Medicaid billing was for hospital outpatient services. DMH must develop new eligibility and enrollment, financial management and contracts management systems that will:

- enhance the timeliness and accuracy of enrollment and eligibility verification (this will require a close working relationship with the MAA);
- improve rate setting and billing;
- fund services by paying for actual services rendered; and
- process contracts , submit and adjudicate claims , and fix problems in a judicious and effective manner.

There must also be more timely information available for decision support, and sufficient budgeting and planning capacity to assure that the system can operate within budgetary limits and that revenues are collected in a timely and predictable manner. Increased management capacity and technology must be created to accomplish these tasks.

The success of this funding strategy is incumbent upon:

- increasing community Medicaid revenues for an array of community services by increasing access, the amount of services provided, and the number of persons served;
- separating the community system from St. Elizabeths Hospital's system for billing, management, service delivery, quality assurance and support; and
- developing incentives for more efficient administrative processes and service delivery.

This strategy will both enable and require providers to build a strong clinical and management infrastructure. Adding the appropriate kinds of administrative expertise and resources can best accomplish this task. These resources should be tied directly to the new Department, so that the Department can effectively build the desired community-based system.

2. Coherent and Consistent Contract Funding System

To be successful, the funding approach outlined above requires a well-defined and developed contract funding system. The system must encourage consistency between services provided by the Department and those provided by contract agencies, as well as create clarity regarding requirements for Medicaid covered and non-covered services. Currently, the CMHS's services contracting is

ill-defined, with varying service definitions and payment methods and inconsistent requirements for contract providers. Further, there is presently no correlation between how either CMHS-provided or non-CMHS-provided services are organized and paid for.

The following steps will be taken to ensure that system funding has a clear rationale, is easily understood and can be administered effectively:

- The Department will develop capacity and establish operating units to implement and manage contracts, manage the flow of information for billing and reporting, and assure that contracts are processed and approved in accordance with District requirements.

- Provider agreements for Medicaid covered and non-Medicaid covered services will be established. These agreements will be uniform across the system, and will apply to Department operated and non-Department operated services. These agreements will guide the funding, service delivery and reporting requirements for Medicaid and non-Medicaid services. The major difference between Medicaid and non-Medicaid services will be the applicability of federal Medicaid requirements to Medicaid service agreements.

- Uniform service definitions, reporting requirements, and payment methods will be established for services not covered by Medicaid (e.g., housing, peer support, etc.).

- For all consumers, eligibility requirements will be established that will provide clarity concerning who qualifies for what services, and the amount of services that can be made available for qualified individuals based on individual need and available resources.

The Department will also collect data on costs, service use and outcomes to explore the potential for new financing methodologies, such as case rates or capitation for selected target populations. For example, the CarePoint Project will provide data that can be useful in determining the viability of using case rates as an alternative to a fee-for-service model. Such alternative funding methodologies should be used when they provide distinct incentives and management advantages, and enable children and youth to succeed more quickly and adults to move expeditiously toward recovery.

G. The Department As A Provider

Serious consideration was given to whether the Department should be in the business of directly providing services at all. There are a multiplicity of non-governmental mental health providers in the District, as well as outside of it, which currently provide inpatient (acute), outpatient and rehabilitative services. Moreover, as discussed above, CMHS's historic dual role has created serious capacity and balancing problems, and similar types of issues have led most

governmental jurisdictions to stop directly providing outpatient/rehabilitation services.

The tests for assessing the propriety of providing Department-run services should be whether the private sector is willing and able to provide a given service, whether these services can be provided more efficiently through the private sector, and whether there is adequate capacity in the community to provide the necessary volume of quality services via the private sector. These inquiries have led to the conclusion that the Department should, for now at least, be a provider for specific mental health services through St. Elizabeths Hospital and a consolidated single-entity CSA.

1. St. Elizabeths Hospital

As discussed above, the primary point of connection and care coordination for consumers in the District's new mental health system will be the CSAs. Secondary acute care services for both children and youth and adults will be provided under agreements with a number of willing and qualified local acute care hospitals with unused capacity. Such agreements are important because general hospitals can be reimbursed for Medicaid-eligible psychiatric admissions, while St. Elizabeths Hospital, as an IMD (Institutions for Mental Diseases), generally cannot. Moreover, acute care hospital inpatient psychiatric admissions will very likely be less stigmatizing, and more likely to result in integrated healthcare and shorter lengths of stay (based on nationwide statistics) than emergency admissions to St. Elizabeths have been. Mechanisms to establish this new system model will be phased in over the next 12 months.

Even after these changes have been put in place, however, the Department will continue to run a rebuilt St. Elizabeths as a forensic hospital and a tertiary care facility to "back up" the new primary (CSA) and secondary (acute hospital) care programs in the community. Initially, St. Elizabeths may need to step in if an acute care hospital is unable to provide the intensity of acute services needed in a particular case. But as the new system and the community hospitals make the necessary adjustments, St. Elizabeths' civil-side role will gradually move to the provision of tertiary care (3-12 months) for individuals whose behavioral manifestations are so severe or intense that they need the security and structure of a public mental hospital. Such changes are consistent with other states' improved management of their limited publicly operated inpatient capacity.

It is clear, however, that there are community-based models, such as the CarePoint Project, that can be developed to meet the demands of even those with significant behavioral challenges or intense care needs. The Department should consider these alternatives as the community system evolves over the next 3 to 5 years. For example, specialized community housing arrangements can and should be created to meet the unique needs of persons who are deaf or elderly as well as mentally ill. Such community-based models are both more normalizing and more likely to achieve better consumer and family involvement than

traditional state hospital wards. *The alternative use of St. Elizabeths discussed below could be one area for this type of specialized development, if it is incorporated into a design that provides opportunities for integrating people with and without a disability.*

Organizationally, St. Elizabeths will have one Director/CEO, with full responsibility for all fiscal, management, and programmatic areas. St. Elizabeths' budget will be discretely identified under the Department's overall budget. The CEO will be held accountable to agreed-upon annual performance goals with programmatic, quality, financial and operational measures established to embody the Department's new mission, values and overall consumer-focused orientation. The Department will seek to provide high quality personnel and procurement support so that the Hospital can attract and retain quality staff.

The goal is to have the new St. Elizabeths run more like a free-standing hospital than a traditional governmental facility. This will require new and improved policies and practices. Innovation — in both St. Elizabeths and the Department's CSA — should be supported at all levels of the Department and the District, with an eye toward the creation of "enterprise-like" entities that can compete in the marketplace.

As the community CSA-based system evolves, for example, DMH should explore the development of a risk-based methodology for funding CSAs. A single rate, which could include the cost of tertiary care for at least persons with serious mental illnesses — including a significant portion of the cost of any required tertiary care at St. Elizabeths — could be established for some or all the persons CSAs are projected to serve. The concept of primary care responsibility could be taken to the next level by making it clear that a person who is admitted to St. Elizabeths remains the clinical and fiscal responsibility of his or her CSA "home." This model could create incentives for St. Elizabeths to be maximally responsive to unmet community needs for tertiary care. It could also support the proposition that the size and role of a state institution is ultimately defined by what the community system cannot do, rather than the other way around.

2. Single DMH-Operated Core Service Agency

As described above, due to the lack of current capacity in the community, the new Department will operate a single Core Service Agency. This CSA will be managed by an Executive Director/CEO, who will have full responsibility and accountability for this agency.

This CSA will be responsible for a range of adult and child and youth services currently provided directly by CMHS, adapted to take full advantage of the MRO approach to service delivery. The CSA will also encompass the CMHS-operated Multicultural Center and MCOTT, so as to create a stronger focus on families throughout the new CSA. While specialized and separate services for children and youth will need to be maintained, duplicative infrastructure (and costs) can be eliminated, and some service sites can serve as models for providing both adult and child and youth services.

The Department-run CSA will exist with the same rules and conditions as any independent certified CSA. For example, consumers will — both initially and on a periodic basis — choose their CSA. Hence, the Department-run CSA will have to compete in the marketplace in which consumers will pick the core service agency of their choice — whether it be the Department-run CSA or a contracted CSA. The Department-run CSA will have to meet the same standards as all other CSAs and will be subject to the same fee schedules for MRO services or any other contracted services. The intent is to create a choice-driven model, as required by Medicaid, with a "level playing field" for all CSAs.

The Department-run CSA will take several years to achieve a proper level of stabilization and development, even with strong leadership. However, as this stabilization occurs, the Department should explore appropriate legal options to enable this CSA to operate as an independent non-profit organization. This would enable the Department to focus its leadership efforts on its authority functions, avoid perceptions of favoritism, and provide the CSA greater flexibility to operate with an independent Board, budget, personnel system, etc.

H. Stakeholders Partnership Council as Advisory Body

The DMH Director will establish a Partnership Council to serve as an active advisory body, providing advice and direction on key policy issues, such as the annual budget, the annual strategic plan, proposed rules and standards, and other major program initiatives or policy changes. The Partnership Council will consist of between 15 and 25 people, representing the various geographic areas of the District and a range of interests and perspectives concerning mental health priorities, programs and practices. To ensure that the voices of consumers are heard at the highest levels, at least 51% of the persons serving on the Partnership Council will be primary consumers or secondary consumers (family members) of system services. The Council shall reflect the varying interests of adults and children, youth and families.

Initially, the consumer and family member representatives on the Partnership Council will be selected by the Director following receipt of nominations from consumers and families. The Director will also name all other members. After these initial appointments, the Council will meet to elect officers and establish bylaws, which shall include a process for selecting or reappointing members. The Partnership Council will formalize a relationship with the Mayor's Mental Health Planning Council, which performs specific mental health planning activities necessary to conform to federal law. There are numerous ways in which these two bodies could collaborate. It is not the intent of this plan to prescribe the relationship, but rather to ensure that these two advisory groups work together toward the shared overarching goal of an improved mental health system. Such a relationship is most likely to evolve if the Director of DMH is responsible for coordinating with the Mental Health Planning Council.

I. Mental Health and Drug and Alcohol Services

Many states provide mental health and drug and alcohol services as part of a single behavioral health system. Other states have successfully created a separate cabinet level Department focused on alcohol and other drugs, which has the statutory authority to coordinate with other health-related departments. At first glance, the levels of co-occurring disorders for persons with serious mental illness and drug and alcohol abuse may seem to point toward some organizational congruence, at least for services delivered to co-effected persons. The two types of services can also avail themselves of similar funding opportunities, such as the availability of MRO.

Given the number of consumers needing both substance abuse and mental health services, the Mayor should be encouraged to create a task force to evaluate the current relationship of the District's mental health and drug and alcohol services, which are administered by the Addictions Prevention & Rehabilitation Agency ("APRA"). This task force should evaluate — from the standpoint of consumers and the experiences of various states — current delivery system(s) throughout the country and recommend programmatic, policy and organizational strategies. In the meantime, the Department should continue CMHS's ongoing planning effort with APRA, targeted toward a pilot effort of co-location and integrated mental health and drug and alcohol services.

IV. WHAT DMH WILL NEED FROM THE MAYOR

A. Local Funding

Under this Plan, the Department will be in a state of dynamic (and at times dramatic) change for a period of 3 to 5 years. This change will include the continued evolution of St. Elizabeths as new community services develop, the building of a new Hospital with a more cost-efficient infrastructure, the creation of a separate mental health authority, the development of an expanded and collaborative housing strategy, and the full implementation of MRO for both adults and children and youth.

The system-wide cost per person served should begin to decrease as these changes occur. The tradeoff, however, is that the system should and must significantly increase the number of people it serves on an annual basis. CMHS-funded services currently serve less than 2% (approximately 1.3% total; 1.4% of persons age 18 and older and 0.9% of children and youth age 17 and younger) of the population of the District of Columbia. This rate is dramatically lower than that of other urban areas, and clearly is not responsive to the compelling need for mental health services for adults and — to an even greater degree — for children and youth. As appropriate natural environment and site-based community mental health services are made more available under this Plan over the next 3 to 5 years, and their existence and benefit become known to the District's residents, it seems reasonable to expect the District's mental health system should reach a service level of 5% or higher across all populations.[1]

It is thus critical that the Mayor do everything within his power to protect the current level of local funding ($138.4 m) to allow this new system time to achieve proper balance and development. Without such support from the Mayor, funds historically earmarked for hospital-based treatment for persons with severe mental illness are in danger of being prematurely diverted from the mental health system, well before the much-needed community-based services can develop and begin to serve the mental health needs of the rest of the community. If such a scenario is allowed to unfold, the District will be unable to sustain the community-based integrated system of care required under Dixon. Thus, the Court will need to maintain an active role in monitoring the City's financial commitment over time.

[1] The District of Columbia Mental Health Needs and Services Estimation Project (1999) estimates prevalence of serious emotional disturbance (SED) at 9, 264 children and youth — representing 7.46% of the total of the District population — of 124,257 children and youth ages 0-17; and prevalence of serious mental illness (SMI) at 23,020 adults representing 5.81% of the total of the District's population of approximately 396, 224 adults.

The commitment not to cut funds to the Department should extend for a minimum of 3 fiscal years, beginning with the 2002 fiscal year budget. This local funding base is needed to provide the 30% match for the MRO program, to support the largely unreimbursable cost of the new Hospital, and to cover the necessary administrative and non-federally funded expenses associated with the new service system. By the close of FY 2004, the new system should be sufficiently developed to permit a fair evaluation and assessment of the appropriate local and federal funding levels necessary to meet the requirements under Dixon and the Court-approved Plan.

In addition to the above, the Transitional Receiver has recently uncovered information raising significant concerns about the historic accuracy of records relating to the anticipated receipt of funds due from Medicare, Medicaid and Federal Beneficiaries under the current hospital-based funding system. As this Plan is implemented, of course, the funding scheme for the Department will transition from a hospital-based reimbursement methodology to the new community-based reimbursement model that takes advantage of the Medicaid Rehabilitation Option. While hospital income will decrease during this period, new revenues generated from the community-based Medicaid Rehabilitation Option will (over the next 2 years) take the place of those lost hospital-based resources. The revenues from Medicare, Medicaid and Federal Beneficiaries, augmented by local funding, currently must support the entire spending plan for the Department. Therefore, inaccuracies such as there may be regarding current funding sources, could raise very serious and basic questions regarding the ability of the Department to finance its planned activities in the short term.

This Plan therefore calls for an aggressive review and analysis of all third party revenues and grants with the intent of validating the current and past revenue projections and to maximizing collections from all third party revenue sources. As the Department stabilizes the current reimbursement methodologies and transitions to the new methodologies, it will be necessary for the Department and the District CFO's office to agree on the total funds to be made available to the Department during this transition phase. The Transitional Receiver recommends that the Department's spending levels should be maintained in total through Fiscal 2001 (transition year) and FY 2002 (first full year under the plan), which may necessitate additional local revenues. During this time, the Department and the CFO's office will reevaluate the fund sources and determine an appropriate revenue projection based on the new Medicaid reimbursement system.

The Mayor's annual budget request to the District Council shall be sufficient to carry out the obligations imposed by the orders in this case, including the mandated provisions in the Transitional Receiver's Plan. The District shall, within two weeks prior to the submission of the Mayor's proposed budget to the D.C. Council, submit the Mayor's proposed budget for the Department of Mental Health to the Dixon plaintiffs for review and comment. Thereafter, the Dixon parties shall confer on the budget proposal and attempt to resolve any issues related to the sufficiency of funding. In the event the Dixon parties are unable to reach agreement, Dixon plaintiffs may seek appropriate relief with the Court within two weeks following the Mayor's submission of the budget to the D.C. Council.

B. Provide Visible and Empowered Support

The Mayor has made a commitment not just to resolve judicially-imposed receiverships, but to work at addressing the underlying problems that caused the Federal Court ultimately to take such action. To that end, the Mayor has engaged a high-level staff person specifically dedicated to helping the City achieve these sound objectives. This support from the Mayor's Office has proven invaluable in working across agency lines in an effective and expeditious manner. Should this dedicated staff support dissolve when the Receivership ends, the Mayor's general staff — which is unfortunately overwhelmed with competing demands for time and attention — will not be able to provide the same level of Mayoral endorsement.

It is therefore recommended that the Mayor continue to dedicate a visible and empowered staff person to work with the evolving new mental health system. This person should have responsibility for troubleshooting problems and actively assisting the Director of DMH with interagency issues and opportunities (e.g., housing, Medicaid, drug & alcohol, law enforcement, and child and youth initiatives). This staffing commitment should extend through FY 2004 — for the same reasons as should the local funding commitment — to be reevaluated at that point.

The expansion of the community-based system and the community placement of Dixon class members from St. Elizabeths will require the Mayor's leadership in the development of affordable housing, especially units that are adapted to the specialized needs of the elderly and persons with physical challenges. Although the Department will continue to work with its own housing intermediary, and will continue to reprogram funds for this expansion, assistance and support is needed to secure Section 8 certificates, establish set-asides and increase federal support for new and existing public and private housing initiatives.

Although the Department will assume a leadership role in partnering with other District agencies, the Mayor's assistance is needed to complete effective, formal interagency agreements. For example, arrangements defining the responsibilities of, and the allocation of resources from, the Mental Retardation and Developmental Disabilities Administration and Adult Protective Services must be identified as soon as possible to prevent continued reliance on St. Elizabeths for adults who have a developmental disability or who are vulnerable due to age or poverty.

C. Offer Leadership on DMH Enabling Legislation

Enabling legislation must be enacted to meet Court-ordered and programmatic deadlines for accomplishing changes in the system. Until this legislation is passed, the new Director of Mental Health and the Department will not have the requisite powers and duties to assume the authority role that is so integral to this Plan. The Transitional Receiver's Office can and will undertake much of the work necessary to achieve this objective. Nevertheless, the enactment of legislation will require the Mayor's enthusiastic public endorsement, as well as that of other City leaders, including in particular the Corporation Counsel and the Deputy Mayor for Children, Youth and Families.

D. Influence Community Attitudes Toward Persons With Mental Illness

The Mayor is in a unique position to alter attitudes toward persons with mental illness, who have historically been excluded and stigmatized by the wider community. As was noted above, the new Department (through its public relations function) will take the lead in developing new community education and anti-stigma initiatives. As this effort unfolds, there will periodically be opportunities, and the need, for the Mayor and his communications office to lend visible support.

E. Involve DMH in St. Elizabeths Campus Development Plans

As the new St. Elizabeths is planned and constructed, it will incrementally free up for alternative use all of the hospital's West Campus and most of the East Campus. Assuming federal cooperation, the District will take on the role of lead planner for the development of this enormously attractive parcel of land and historic buildings. The District should take advantage of this incredible opportunity for creative alternative use planning, and the multi-year process should be started as soon as possible.

The new St. Elizabeths Hospital will eventually become one of the multiple tenants in this new St. Elizabeths community. Department leadership should play a significant role in the planning process to facilitate smooth transitions as the Department vacates buildings and land. It will also help ensure that the special needs of persons with mental illness (e.g., housing and vocational opportunities) are fully appreciated and included in the overall master plan as this new community takes shape.

Until such time as an overall plan is developed and approved, the District should resist any piecemeal efforts to locate other non-mental health services or programs on the St. Elizabeths campus.

V. TRANSITION PHASES

As has been noted, this Plan must be implemented over a number of years. The fundamental infrastructure necessary to achieve meaningful systems development does not currently exist, and must be put into place as quickly as possible, or every program initiative discussed in this Plan will be at risk. The implementation of this Plan must be deliberate, inclusive and expedited, through solid organizational and legal building blocks to support the new system. In the face of a long history of failed promises, it is critical that the system be constructed on a foundation of demonstrated performance. With these precepts in mind — and working within the framework of the existing consent order appointing the Transitional Receiver — Plan implementation will occur in three basic developmental phases.

A. Phase I

To enable the new system to move forward with a solid base of infrastructure development and community support, the following milestones are critical to providing a solid foundation for the new system.

1. MRO Program Developed and Approved by Medicaid

The new Medicaid Rehabilitation Option should be fully developed and approved by the Medicaid administration (MAA and HCFA). The policies, standards, information and payment systems and certification teams necessary to begin actual implementation must be in place. Although this is a major undertaking that will require extraordinary effort, the old method of flowing Federal funds to community agencies is no longer viable. It is also true that the new community system (the CSAs) will be shaped by the nine services envisioned in the MRO program. Hence, moving forward as quickly as possible on MRO is absolutely essential.

2. Begin Development of DMH Authority Functions

To implement the MRO and CSA components of the Plan, it is essential that the new Department begin to put into place the authority functions outlined above. The leadership capacity and specific competencies needed to carry out these functions must be created. This will require a major commitment (internally and externally) to identify the leadership necessary to support the new system. While this authority development will occur incrementally over the next 12 to 18 months as the systems grow, the key leadership needs to be in place in order for early development to take place on a solid basis.

Because this current-year development of the authority functions was not anticipated in the original 2001 budget, the major 2001 budgetary cost centers will have to be modified to match the four major cost centers of the new and evolving structure: the mental health authority, the department-run core service agency, contracted-for community services, and St. Elizabeths. The preexisting budget structure fell entirely under St. Elizabeths Hospital.

3. Hire DMH Director

As indicated earlier, the Director will be a cabinet level position reporting directly to the Mayor's office. The Mayor should therefore make the final hiring decision on the Director, but this decision must be made with the concurrence of

the Transitional Receiver and in consultation with the Plaintiffs. It is also advisable that a reasonable cross-section of other interested parties be included in the interview process. The obvious goal is to attract and employ a very high quality person to this key leadership position. The new Director should be hired as soon as possible so that he or she can be involved in the early development and leadership of the system, and to provide continuity between the Director and the Transitional Receiver. This process, in which the Mayor's Office has been participating, is well underway as of this writing, and the Transitional Receiver anticipates that the new Director will be hired as soon as possible.

4. Enabling Legislation in Place

The new Department requires enabling legislation to provide the powers and duties necessary to function both as an authority and as a reconstituted provider. This legislation must replace and supersede current legislation and executive orders regarding the existing Commission on Mental Health Services. It must clearly designate the new Department as the District agency primarily responsible for meeting the public mental health needs of the District's residents. To meet the mandates of this Plan, this or other legislation must accomplish a number of things, including but not limited to the following.

- It must strengthen and update the protections for all consumers receiving public mental health care.

- It must place all relevant authority for mental health licensure, certification or oversight with DMH, including the authority to certify CSAs and to license Community Residential Facilities.

- It must amend the Mental Health Information Act to reaffirm the necessary protections of medical information privacy, consistent with the requirements for good continuity of care.

- It must create an alternative planning, review and approval process within DMH for community-based services certified or licensed by the Department, that is consistent in policy intent with the existing Certificate of Need ("CON") statute but replaces that function for mental health services.

- It must establish independent DMH personnel and procurement authority within the new Department, consistent with District law, which will work in partnership with the District's Personnel and Procurement offices to develop exemplary polices and practices in both

of these areas. This will maximize the Department's ability to operate time-efficiently in these areas and to develop contemporary personnel and human resource practices so that it can compete in the health care marketplace.

- It must establish the responsibility of the Department to achieve joint commitment across all systems to change and to build a single system of care for children, youth and their families.

- It must make the new Department's key leadership accountable to the DMH Director, as described above, while at the same time requiring compliance with relevant District laws and policies in specific areas.

In addition, legislation amending the Ervin Act must be proposed as soon as possible, and before the D.C. Council adjourns for the summer of 2001. The Ervin Act must be amended, for example, to increase community access points for consumers as required by Federal law and to make it feasible for community hospitals to provide acute care psychiatric hospitalizations.

5. Beginning the Expansion of Community Services

Adoption of the MRO presents the opportunity to develop expanded and extended community services. Some existing services will be broadened, and several entirely new services (including Assertive Community Treatment, Community Based Intervention, Emergency/ Crisis, Partial Hospitalization and Rehabilitation) will be made available. These services should be offered to persons who are eligible for Medicaid or public mental health services under the Department's criteria. The Department must also give high priority to the development of services and resources not covered under the MRO, including but not limited to supported housing, supported employment, consumer operated services and non MRO covered crisis stabilization. While the development of expanded and extended community services will take place over time, it should begin during this Phase I period and move aggressively forward in the months that follow.

A specific plan for the development of these services and the expansion of housing opportunities should be put in place for persons currently hospitalized at St. Elizabeths Hospital and those at risk of hospitalization. This plan should be

based on a current and ongoing assessment of each person's level of care and service needs to assure that persons who do not require an inpatient level of care will be given the opportunity to live in the most integrated community setting possible.

The Department must take the lead in the development of such services, for children, youth and their families, as well as for adults, so that critical improvements in and progressive development of community services can be achieved. Such targeted improvements must include the following.

a. Initiation of Community Support Services (CSP) and Community Based Intervention (CBI) services is the first priority for children, youth and families. These services will enable the system to develop community care teams, wrap-around services and kinship and family support programs.

Wrap around is a one-on-one service provided by trained professional teams in the home of the child or youth and their family or a surrogate family, and in other community settings such as the classroom. The service can be provided intensely for families in crisis, or scaled down for families learning new skills or needing help over time. All of these services are essential if the Department (and the partner service systems, such as Child & Family Services Administration (CFSA) and the Board of Education (BOE)) are to be successful in returning children more quickly from out-of-home placements or in avoiding such placements altogether. These developments, along with creation of a range of crisis stabilization alternatives — both in home and out of home — should enable these systems to provide alternatives to acute care hospitalization or to shorten those lengths of stay.

The Department must also devote the resources necessary to assure that children and youth with multiple or special needs can be accommodated and well-served in this new system. This consumer group includes children and youth in the juvenile justice system and those who have been labeled as sexual offenders and victims of trauma including rape, incest or other physical or emotional abuse; it also includes those who have serious emotional problems in addition to being physically handicapped, deaf or hard of hearing, developmentally delayed, or behaviorally challenged. Youth transitioning to adulthood, especially those who are unable to face the challenges of adulthood successfully without special help currently unavailable from the adult mental health services system, also require particular attention.

The new Department must give priority to developing these alternatives through an organized network of providers and CSAs using a care coordination and management approach. This system should be CSA-based, and developed collaboratively with partner service systems and the Medical Assistance Administration and its health plan organizations. The system should assure that each child or youth and his or her family is the focus of a single, integrated and family-centered treatment planning process facilitated by a well trained clinical case management team. These teams must be trained in the use of alternatives to hospitalization/long term community residential placement. Based on experience in other communities, the mental health system and its partner agencies will be able to utilize these services and this approach to reduce non-community placements and utilize private hospitals for acute care services.

b. The Department must also move aggressively to further the development of community service alternatives for adults. This development should be organized and implemented with the same attention to availability and flexibility of resources as has been done successfully for persons assigned to the CarePoint Project. In the next year, priority should be given to the areas described below. It should be noted that development of these resources within this timeframe and at a level sufficient to meet the level of needs of consumers in these priority categories will require significant re-allocation of existing resources in the CMHS budget from inpatient to outpatient services.

1. A pilot program should be developed for adults housed on the forensic side of St. Elizabeths Hospital who have received the maximum benefit from hospital treatment in the Forensic Program and who, consistent with public safety, could benefit from living in the community and receiving recovery oriented community treatment and support. This pilot program should have three components. First, due to the legal status of such persons, the Superior Court will retain primary control over them and there should be a tracking system to monitor the clinical care as closely as necessary based on the individual's clinical needs and their legal circumstances. The second component is specialized Assertive Community Treatment ("ACT") Team services for every person leaving the hospital. It should be established as defined in the MRO standards but with staff assigned to the ACT who have experience working with persons with a forensic status. The third component is simply that each person assigned to this pilot should have full access to community services and resources that best meet their needs, consistent with the access to financial and other resources being made available through the CarePoint pilots. Such resources should include the provision of appropriately designed and supported community housing. Thus the pilot program should include the contractual relationships with CSAs that will

have the ability to organize services and resources to assure such persons have the access they want and need.

2. For current "long term" civil patients at St. Elizabeths for whom community placement is recommended, and for persons who can be diverted from long hospital stays before becoming long term patients, CSAs must form ACT and/or Community Support Teams. The CarePoint Project should also be expanded over time as part of this development. For "long term" and potentially long term patients, the benefit acquisition process should be started as early as possible and recovery plans developed to include the needed transition and community support services that will be needed prior to and following discharge into the community.

Community staff assigned to such support teams should begin taking responsibility for discharge planning as soon as such persons are identified as discharge ready, so that staff can begin building a relationship with the person being discharged. Community Support Teams and ACT staff also should have access to community resources and should initiate the benefit process to effectuate a smooth and timely transition to community living and access to community resources, including any necessary bridge funds for initial housing support to network providers. If necessary, community support must be available daily for persons in this transitional stage. Peers and staff should also be available to provide one-on-one support until such a person is safely and securely settled into their home and daily routine.

Based on a more detailed analysis of specific needs, the Department should request that CSAs develop ACT and Community Support Teams for specific groups of persons with high risks and assure the availability of staff who have skills and training in serving the high-risk groups as necessary. These high-risk groups include persons with dual disorders or disabilities, persons who are deaf, older adults and persons with physical handicaps or challenging medical needs.

3. The Department shall seek to expand the civil-side community system to include private hospitals who, through agreement with the Department and the CSAs, will admit DMH consumers appearing voluntarily and/or pursuant to a court order. The agreements with CSAs will include very specific continuity of care arrangements under which the CSAs will accept persons ready for discharge to ACT and Community Support Teams, and the commitment to meet judicial obligations that may exist . This will help build a stable network of community services (including inpatient services) for persons who would otherwise have only St. Elizabeths as an alternative.

4. The Department must also establish a review process to measure level of functioning and acuity of need in order to triage persons into the most appropriate care system. The review should be undertaken when such persons enter the system through the Hub or at one of the CSAs. The objective of the review will be to identify persons who do not meet the criteria for inpatient hospitalization but need intensive

outreach and community-based services either in conjunction with crisis stabilization services or in lieu of crisis stabilization.

Ideally this process of identifying acuity and determining functional level of need should be used for everyone entering the system, whether or not they are hospitalized. This assures that consumers are receiving the level and type of supports needed for recovery and should help consumers and staff monitor the consumer's recovery and health status. Implementation of a regular and uniform review process for all persons receiving services on an ongoing basis in the community (including acute care hospitals) or at St. Elizabeths will minimize people stagnating in one place and will aid in the determination of priorities for development of resources as well as in the assessment of the need for bed capacity at St. Elizabeths.

c. Planning for affordable and accessible housing is a major challenge and widely regarded as critical to the recovery and successful community adjustment for adults with serious mental illness and youth with emotional problems transitioning into adulthood. The Commission has been engaged in a planning process to update its housing plan. The new Department should complete that Plan no later than June 1, 2001.

In FY 2001, CMHS was able to successfully reprogram $3.9 million from funds no longer needed in the capital budget for use in developing new housing units for persons with mental illness. CMHS has also recommended that the District provide an additional $11,100,000 over the next two years for the purpose of developing and subsidizing a minimum of 300 additional new housing units for the three year period.

The plan should specify housing development targets, support strategies, and goals for leveraging additional public and private funds for development and subsidies. The plan must also address approaches for partnering with other local and federal government agencies and foundations with housing resources to meet the needs of this population.

6. Beginning Planning for the New St. Elizabeths

This plan contemplates the consolidation of the current St. Elizabeths Hospital onto the East campus and the construction of a new hospital building to house most, if not all, of St. Elizabeths' remaining hospital capacity. While this effort will take time, planning for it must begin in this Phase I period. As of this writing, the architectural and engineering bid was under negotiation, and it should proceed as rapidly as possible. It is expected that:

- *The new hospital will be built over a 3-year period, with a projected completion date of late 2004.*

- *There will be a minimal level of inpatient hospital services, both civil and forensic, to ensure the needs of the mentally ill are met.*

- *Service arrangements with acute care hospitals will be in place within the next 12 months. It is anticipated that service agreements for child and youth services will be in effect by April 1, 2001.*

- *This will allow St. Elizabeths to function (by FY 2002) as a tertiary hospital on the civil side, as the CSAs, as the primary providers of care, gradually assume care management responsibilities, and the Hub service and local acute hospitals provide a secondary level of back-up for persons in crisis.*

- *Currently hospitalized individuals determined by their treating professionals to no longer need hospitalization must be returned to the community and provided the necessary supports through agreements with CSAs, and through expansion of Community Support Teams, ACT (including specialized teams where necessary) and the CarePoint Project.*

- *Housing initiatives will be intensified, as contemplated by the recent reprogramming and programming over the next three years of over $15 million to expand the array of affordable housing for persons served by DMH and CSAs.*

- *The development of care management, community support and wraparound services for children through the CSAs will enable the Department to establish agreements with community hospitals to provide acute care for children and youth.*

- *St. Elizabeths' statutorily-mandated role as a forensic hospital will not change, but the Department will develop community initiatives for persons with a forensic status as part of an overall forensic services plan, beginning with the forensic community services pilot plan referred to above.*

Despite these expectations, many questions remain as to the appropriate sizing and staging of the new St. Elizabeths. On January 22 and 23, 2001, the Transitional Receiver convened a special task force to discuss and elicit recommendations and feedback on the future of St. Elizabeths. The input from that task force validates the direction being taken for community planning, but it also identified various additional concerns and conditions that will need to be addressed by DMH, the parties and the community in order for the plan to be successful:

a. Current St. Elizabeths patients for whom community placement has been recommended must be placed in the community as promptly as possible. For all other current St. Elizabeths patients, the Department should establish a level of care review process, with a projected completion date of July 1, 2001, in order to

identify others for whom community placement may be appropriate. This process should be used for persons on both the civil side and the forensic side of St. Elizabeths, although the forensic review process should be adapted to recognize legal constraints as well as the projected program or policy impact of other related systems (e.g., D.C. Jail, U.S. Marshals, etc.). Consumers and staff with first hand knowledge of community services and staff with strong clinical and community support knowledge should be involved as participants and advisors in the overall level of care review process. The outcomes of this review should help inform community and hospital planning, defining the range and scope of needs of persons in the review.

The level of care review will be adapted for long term use by the Department and its CSAs for determining the appropriate level of care and services for each consumer based on the acuity of his or her needs and his or her own recovery plan. Tools used in this process may also be used by consumers and their clinical management teams to track outcomes and team performance. The review process should also assist the Department in planning for the allocation of resources.

b. Planning should be based on several important principles. First, the design of the new hospital should provide for maximum flexibility to facilitate adjustments in levels of security between the civil and forensic populations. Second, the new hospital's design should accommodate varying degrees of security within forensic services so that forensic patients are able to incrementally advance to less secure areas as their treatment teams and the courts may concur that such changes are appropriate. Third, the new Hospital should be sized to reflect the development of a reasonably mature community system within 3 years, and the phasing down and closing of existing wards and buildings as the community system develops. Fourth, given patient needs and the critical need to relocate long term hospital patients to appropriate community settings, priority for the new beds being planned should be given to:

- *forensic patients (maximum through minimum security),*
- *acute care patients (to back-up community acute system as needed) and*
- *intermediate stay patients (3-12 months).*

c. A more definitive determination concerning the number of beds needed on the civil side of the hospital should be reached based on the outcome of the level of care review process described above, and the conditions of the review should also be accommodated in the planning.

d. As the District develops a master plan for the St. Elizabeths campus, DMH must be included in the overall planning efforts. One critical opportunity – given the overall scarcity of housing in the District – is to develop specialized housing for persons with special needs. These smaller and scattered site units could be designed and staffed with special populations, such as persons with special health care needs, in mind. This is intended to supplement the other housing initiatives underway.

7. Performance Measures Developed

An overall methodology for measuring systems performance must be put in place. This is a critical component of any system, but is especially important in an evolving new system of care. There are innumerable areas in which measurement could be meaningful. However, as a practical matter, no system can adequately incorporate endless measures.

A subset of the "most meaningful" performance measures needs to be articulated and measured consistently over time. These measures should be developed in at least four areas: access, quality, cost-efficiency and systems support. Some measures may well be structural indicators (e.g., was the Medicaid Rehabilitation Option implemented or not?); some may be process indicators (e.g., were service guidelines or standards met?); and some may be outcome indicators (e.g. do consumers make improvements and how satisfied are they?).

This overall methodology is to be developed, broadly reviewed, and put in place promptly pursuant to a schedule to be developed by the Director, and the Transitional Receiver, so that it can then be utilized as part of a larger systems improvement philosophy. The objective is to develop consistently measured data which can be used to chart service improvement efforts. This will be a part of the Department's ongoing quality assurance/enhancement program.

B. Phase II

The Court's order decrees that the Transitional Receiver move into a monitoring role for a six-month period following transfer of responsibility for the day-to-day operations of the mental health system to the District government. During the Phase II monitoring period, the District will enter a probationary period. The Transitional Receiver's responsibility will then be to monitor the District's compliance in implementing the Plan approved by the Court. The Transitional Receiver will establish a monitoring schedule. The Transitional Receiver will also prepare a monitoring budget for Phase II. This budget will be received by the parties prior to its submission for Court approval.

In Phase II, the DMH Director will have full operational responsibility for the Department pursuant to the terms of the original Order. The Director, with the support of the Mayor and the enabling legislation, will have the responsibility for managing the affairs of the Department. The Director will work closely with the

Transitional Receiver to ensure a smooth transition from the active stage of the Receivership through the monitoring stage. The Director should take the lead in the development of the FY 2002 Strategic Plan for DMH. The FY 2002 strategic plan will use the Receiver's plan to provide direction for setting priorities, timelines and resource allocation. The Transitional Receiver will have full opportunity for review and comment on the strategic plan as to adequacy and congruence with the Receiver's Plan.

One responsibility of the new Director will be to provide quarterly written reports outlining the progress the District is making in implementing this Plan. In these reports, the Director will be required to identify impediments to timely and successful implementation, and to work with the Mayor to propose additional supports needed to achieve the progress envisioned under this Plan.

The Director and the Transitional Receiver will develop, in consultation with the parties, specific measures for monitoring the performance of the District during Phase II and exit criteria for the termination of the Receivership. Performance measures shall be developed at the earliest opportunity, and no later than 30 days following the date on which the new Director begins employment. The exit criteria shall be developed at the earliest opportunity, and no later than 120 days following the date on which the new Director begins employment. In the event the Transitional Receiver and the new Director are unable to reach agreement, or that either party objects to the performance measures and/or exit criteria, the parties shall present their respective positions to the Court, which shall make a determination consistent with the orders and decrees in this case.

C. Phase III

If, at the conclusion of the probationary period, the Transitional Receiver certifies that the District is capable of implementing, and is implementing, the Plan, the Receivership will terminate at the end of Phase II. It is important to anticipate and plan for the post-Receivership phase, however, because it is the performance of the new Department post-Receivership that will determine the success of the Plan and the capability of the District to operate an effective and efficient mental health system.

As has been noted above, the criteria established by the Court will serve as the basis for Phase III monitoring. As the specific criteria are established, protocols and methodologies for monitoring each of the criteria will also be adopted. It is anticipated that there will be a process of progressive disengagement. As demonstrated progress is made on specific criteria, such criteria will be deleted from the monitoring list. The ultimate goal — following the achievement of substantial and sustained compliance by the District — is the resolution and dismissal of the underlying Dixon case itself.